Illinois Department of Public Aid

no. : Ch A 200-01-2

ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER BULLETIN

11/16/01

TO: Participating Physicians, Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Encounter Rate Clinics and Advanced Practice Nurses

RE: Clarifications on Policy and Billing Procedures

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The purpose of this bulletin is to notify providers of revised pages to Chapter 200, the Handbook for Physicians, clarifying several policy and billing procedures. The changes are briefly addressed here and in detail in the replacement pages to the handbook.

- Topic A-201 is being revised to clarify the only circumstances under which a physician may designate an alternate payee.
- Topic A-202.1 is being revised to clarify the Department's policy regarding services provided by a physician assistant or an advanced practice nurse when the collaborating physician bills the Department using his or her name and provider number.
- Topic A-229.1 is being revised to clarify the Department's reimbursement policy relating to the administration of chemotherapy.

The changes are detailed on replacement pages available on the Department's website. The Internet address is **http://www.state.il.us/dpa/html/physicians.htm**

The documents are in Adobe Portable Document Format (PDF). In order to view or print the documents, you will need to have Adobe Acrobat Reader installed on your computer. Adobe Acrobat Reader is available to download FREE from the Adobe homepage at **http://www.adobe.com**

Once you are in the Department's website, go to Medical Programs. Under the heading Providers, select Provider Releases, and under Provider Releases select Physicians. The revised pages will be labeled Handbook Revisions.

If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request.

To ensure delivery, you must specify a physical street address when making a request for a paper copy. Submit your written request or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800

The revised handbook pages are dated November 2001. The affected items are designated by a "=" sign in the left margin. This bulletin lists the pages to be removed and replaced.

INSTRUCTIONS FOR UPDATING HANDBOOK

Topic A-201 Physician Participation
Remove pages dated December 1998 II-A-2 and II-A-3 and insert pages II-A-2 and II-A-3 dated November 2001

Topic A-202 Physician Reimbursement
Remove pages dated December 1998 II-A-5 and II-A-6 and insert pages II-A-5 and II-A-6 dated November 2001

Topic A-229 Chemotherapy for Malignant Disease
Remove pages dated December 1998 II-A-36 and insert page II-A-36 dated November 2001

If you have any questions regarding this bulletin, please contact the Bureau of Comprehensive Health Services at (217) 782-5565.

SECTION II

CHAPTER A-200

Physician Services

A-200 BASIC PROVISIONS

For consideration of payment by the Department for physician services, such services must be provided by a physician enrolled for participation in the Illinois Medical Assistance Program. Services provided must be in full compliance with both the general provisions in Chapter 100 and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

A-201 PHYSICIAN PARTICIPATION

A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois (or state of licensure) license to practice medicine in all its branches, is eligible to be considered for enrollment to participate in the Medical Assistance Program.

- Residents generally are excluded from participation as the cost of their services is included in the hospital's reimbursable costs. If, by terms of their contract with the hospital, they are permitted to and do bill private patients for their services, participation may be approved.

- Hospital-based physicians who are salaried, with the cost of their services included in the hospital reimbursement costs, are not approved for participation unless their contractual arrangement with the hospital enables them to make their own charges for professional services and they do bill private patients and collect and retain payments made.

- Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill private patients and collect and retain payments made.

- Teaching physicians who provide direct patient care may be approved for participation provided that salaries paid by hospitals or other institutions do not include a component for treatment services.

A physician requesting to participate in the Illinois Medical Assistance Program must also meet the following criteria:

1) Be licensed to practice medicine in all its branches. Out of State Physicians shall have unrestricted licenses to practice medicine and surgery in the state in which they practice. Consultants shall be board qualified or board certified in their specialty.

2) Be prepared to provide, if requested by the Department, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to Public Aid recipients.

A-201 **PHYSICIAN PARTICIPATION** (Continued)

3) If providing maternity care, have hospital delivery privileges or have a written agreement with a physician who has such privileges.

The provider must agree to:

- verify eligibility prior to providing services.
- allow clients the choice of accepting or rejecting medical or surgical care or treatment.
- provide supplies and services in full compliance with all applicable provisions of state and federal laws and regulations pertaining to nondiscrimination.
- hold confidential and use for authorized program purposes only, all Medical Assistance information regarding recipients.
- furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services or in connection with the rendering of goods or services or supplies to recipients.
- make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges.
- accept as payment in full the amounts established by the Department.
- accept assignment of Medicare benefits for Public Aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department.

It is required that each physician **must** enroll with the Department in order to be considered for participation.

PROCEDURE: The physician must complete and submit:

-	Form DPA 2243	Provider Enrollment/Application Form
-	Form DPA 1413	Agreement for Participation
-	Form DPA 2307	Hospital, Professional School or Group Practice as Alternate Payee (if applicable)
-	Form DPA 2306	Power of Attorney (if applicable)
-	Form DPA 1517/1517A	Provider Forms Request

These forms may be obtained from:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the physician, and returned to the above address. The physician should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the physician requests a specific enrollment date.

= An Alternate Payee, Form DPA 2307, may be designated to address the physician's circumstances, which must meet one of the following conditions:

- The physician has a contractual or salary arrangement, as a condition of employment with a hospital or professional school.

A-201 **PHYSICIAN PARTICIPATION** (Continued)

= C The medical practitioner is part of a practitioner-owned group practice consisting of three or more full-time licensed practitioners or the equivalent thereof.
C The physician is employed by a practitioner who requires, as a condition of employment, that the fees be remitted to the employer.

A-201.1 **PARTICIPATION APPROVAL**

When participation is approved, the physician will receive a computer-generated notification, the Provider Information Sheet, listing all data carried on Department computer files. The physician is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix A-7. If all information is correct, the physician is to retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information required is an exact match to that in the Department file. If incorrect, refer to Topic A-201.31.

A-201.2 **PARTICIPATION DENIAL**

Written notification to a physician of denial of an application for participation will include the reason for the denial.

Within 10 days after such notice, the physician may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within 10 days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. (See Section III, General Appendix 7A, Rules For Department Actions Against Medical Vendors and General Appendix 7B, Rules For Practice For Medical Vendor Administrative Proceeding.)

A-201.3 **PROVIDER FILE MAINTENANCE**

The information carried in Department files for participating physicians must be maintained on a current basis. The physician and the Department share responsibility for keeping the file updated.

A-201.31 **Physician Responsibility**

The information contained on the Provider Information Sheet is that carried on Department files. Each time the physician receives a Provider Information Sheet, it is to be reviewed carefully for accuracy.

Inasmuch as the Provider Information Sheet contains information to be used by the physician in the preparation of billing statements, any discrepancies are to be corrected and returned to the department for correction within 30 days of the change.

A-201.3 **PROVIDER FILE MAINTENANCE** (Continued)

A-201.31 **Physician Responsibility** (Continued)

PROCEDURE: The physician is to line out the incorrect data, enter the correction, and sign the Provider Information Sheet on the line provided with an original signature. The Provider Information Sheet, with appropriate corrections, is to be sent to the address below or to the address on the reverse side of the Provider Information Sheet:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Any time a physician effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified in the same manner as indicated in the preceding paragraph. When possible, notification should be made in advance of a change.

Failure of a physician to properly notify the Department of any corrections and/or changes, including the effective date of such changes, may cause an interruption in participation and payments. Refer to General Appendix 7A and 7B.

Confirmation of the requested change will be sent to the physician in the form of an updated Provider Information Sheet. Upon receipt of the corrected Provider Information Sheet, invoices may be submitted.

A-201.32 **Department Responsibility**

Whenever there is a change in a physician's enrollment status, an updated Provider Information Sheet will be generated indicating the change and the effective date.

A-201.4 **BILLING FORM DISTRIBUTION**

The Illinois Department of Public Aid (IDPA) will distribute billing invoices and envelopes only upon written request or receipt of form DPA 1517/1517A (Provider Forms Request) which is included with the enrollment application and with each supply of forms delivered. Physicians in Cook, DuPage, Kane, Kankakee, Lake, Winnebago, and Will counties must use the DPA 1517A. Physicians in all other counties are to use DPA 1517.

IDPA FORM NUMBERS are to be listed exactly as they appear in Appendix A-8 of this handbook. When ordering the forms and envelopes, request the specific number needed of each item for a three month period. Allow 30 days for delivery.

A-202 PHYSICIAN REIMBURSEMENT

A-202.1 CHARGES

Physicians are to make charges to the Department only after services have been provided. Charges are to be the physician's usual and customary charges to non-Public Aid patients for the services provided.

= Except as otherwise noted in this handbook, e.g., Topic A-210.4, a physician may charge only for services personally provided, or which are provided under direct supervision in the physician's offices by licensed or certified staff, e.g., laboratory tests done by a technician in the physician's employ.

A physician may not charge for services provided by another physician even though one may be in the employ of the other. The treating physician, if it is a condition of employment, may elect to have payment directed to the employing physician under the alternate payee option allowed in the provider enrollment process.

EXCEPTION: A physician is allowed to bill for a service provided by another physician when the second physician is "substituting" for the attending physician. This provision is to cover situations where the attending physician is ill, on vacation, or because of an emergency situation. The substitute physician does not have to be enrolled in the Medical Assistance Program, but is required to be a licensed physician as defined in Topic A-201. In addition, the substitute physician may not be terminated, suspended, barred or otherwise excluded from participation or have voluntarily withdrawn from the program as part of a settlement agreement. The time limitations are 14 days for a single incident and up to a maximum of 90 days
= per year for the attending physician. If the substitute period extends beyond the 14 days per single incident, the physician must enroll with the Department.

PROCEDURE: The attending physician should bill the Department in the usual manner and show the name and the provider number plus "S" of the substitute physician in field 19 (referring Physician Number) of Form DPA 2360, Health Insurance Claim Form. The attending physician retains the responsibility for any quality of care issues. For Department audit purposes, it would be advisable for the physician to maintain on file a copy of an agreement between him/her and the substituting physician.

If a physician provides any services in a hospital setting, he/she may charge for the services only if he/she is not reimbursed by the hospital and the hospital does not include the cost of the physician's services in the hospital's reimbursable cost statement. It is the responsibility of the physician, if charges are made for such services, to verify that the services provided are not included as a part of the contract with the hospital.

To be paid for services, all claims, including claims that are rebilled, MUST BE RECEIVED WITHIN ONE (1) YEAR OF THE DATE OF SERVICE.

A physician may not charge for services provided outside the physician's office by anyone other than the physician.

A-202 **PHYSICIAN REIMBURSEMENT** (Continued)

A-202.1 **CHARGES** (Continued)

= **Exception:** A physician may submit a bill for services provided by an Advanced Practice Nurse (APN) or a Physician Assistant (PA), in any setting, as long as such practice is not in conflict with the:

- Nursing and Advanced Practice Act (225 ILCS 65)
- Physician Assistant Practice Act (225 ILCS 95)
- Department of Professional Regulations rules for administration of Physician Assistant Practice Act (68 Ill.Adm.Code1350)
- Department of Professional Regulations rules for administration of Nursing and Advanced Practice Nurses Act (68 Ill.Adm.Code1305)

A-202.11 **Allowable Charges By Teaching Physicians**

Teaching physicians who provide direct patient care may submit charges for the services provided, if the salary paid them by the hospital or other institution does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

Charges are to be submitted only when the teaching physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, this means presence in the operating room, performing or supervising the major phases of the operation taking personal responsibility for the services provided, and personally performing services considered necessary to confirm the diagnosis and findings. For non-surgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching physician is personally responsible for all services provided and is personally involved by having direct contact with the patient.

The patient's medical record must show that these requirements have been met. All such entries must be signed and dated by the physician seeking reimbursement. A signature may be actual or electronic. Signature stamps are not acceptable.

A-202.12 **Services Provided By Hospital-Based Physicians/Salaried**

Reimbursement for services provided by a **salaried** hospital-based physician to a client is included in the hospital's reimbursement rate. There is no separate payment to the hospital for the physician's services, and no charges should be submitted to the Department by the hospital or the physician with **one** exception. When services are provided by a salaried physician and those services are provided in the Out-Patient or the Emergency Department, hospitals may bill for the services provided by **one** salaried Emergency Department physician on Form DPA 2360, Health Insurance Claim Form, in addition to the Ambulatory Procedure Listing (APL) billed on the UB-92. If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as fee-for-service.

If the hospital provides a non-emergency/screening service, the hospital has the option of billing for the screening services on the UB-92 or the DPA 2360, **but not both**.

A-228 **ALLERGY SERVICES**

Allergy sensitivity tests and desensitization services provided by a physician are covered when documented in the client's medical record.

The initial office visit for allergy investigation is considered a comprehensive office diagnostic visit. Appropriate skin tests, sputum and nasal secretion studies and other essential services are covered.

PROCEDURE: CPT procedure codes listed under **Allergy Testing** are to be used for allergy sensitivity tests. Enter in Field 24C, of DPA 2360, the CPT procedure code which coincides with the number of tests performed.

Enter in Field 24F (Days or Units) the **actual** number of tests provided. This entry must be in a four digit format, e.g., the entry for thirty (30) tests is shown as 0030.

EXCEPTION: No entry should be made in Field 24F (Days or Units) for the following codes: 95060, 95065, 95070, 95071, 95075, 95078. A brief description and the number of tests should be entered in Field 24C.

After the initial office visit, appropriate established patient office visit codes may be billed. However, procedure code 99211 must be used when the reason for the visit is for the client to receive desensitization (allergy injections) only.

PROCEDURE: CPT procedure code 99211 is to be used when charges are made for visits for allergy injections only. An additional charge may be made for the cost of the allergy extract given. Appropriate CPT allergen or immunotherapy codes are to be used.

When more than one allergy injection is administered on the same date of service, procedure code 95199 (Unlisted Allergy Service) is to be used with a separate charge which includes all the additional injection(s) and a description of the service entered in Field 24C. Please specify the number of additional injections.

When an allergist prepares a vial of extract and provides it to another physician for administration, the allergist may make a charge for the vial(s) of extract. **The administering physician may not bill for the cost of the allergy extract, only the injection.**

PROCEDURE: The appropriate CPT procedure code for allergen immunotherapy vials is to be used for the first vial. The "unlisted" allergy service code is to be shown with a second charge for the additional vial(s). The service description and number of additional vials is to be entered in Field 24C.

A-229 **CHEMOTHERAPY FOR MALIGNANT DISEASE**

= Payment for chemotherapy administration may be made to physicians, APN, (when administered in accordance with the Nursing and Advanced Practice Nurse Act, 225 ILCS 65), and to hospitals billing fee-for-service. Physicians and APNs may bill for the administration of chemotherapy in the office, hospital inpatient, hospital outpatient and emergency room settings. Hospitals may bill fee-for-service for the administration for office, hospital outpatient and emergency room settings.

Only one administration fee per day is reimbursed, even when multiple drugs are administered. No payment is made for venous or arterial puncture performed for the purpose of administering the chemotherapy. Separate payment is allowed for an initial visit the day of chemotherapy administration, however follow-up visits are included in the chemotherapy administration fee.

Physicians and hospitals may make separate charges on Claim Form DPA 2360 for the chemotherapy agents or drugs and non-chemotherapy injectable drugs given with the chemotherapy and related supplies. The drugs and supplies are payable to physicians for the office setting only. Hospitals may bill fee-for-service for the drugs and supplies for office, hospital outpatient and emergency room. Hospitals may bill on the DPA 2360 Claim Form for the drugs and supplies even if no administration fee is billed. Anti-emetic drugs are types of non-chemo drugs usually administered with chemotherapy. **NOTE:** A DPA 215 Pharmacy Claim should be not be submitted for the drugs or supplies used in the administration of the chemotherapy.

PROCEDURES:

Chemotherapy Administration: Use the appropriate CPT code for the method of administration with a single charge for each date of service.

Chemotherapy Drugs: Use the CPT code for "provision of chemotherapy agent" (96545) and show one total charge for each date of service. The drug name, strength or potency and dosage/quantity for each drug given must be entered in the description field of the claim (24C) or on an attachment to the claim. The NDC number(s) may also be shown, if available.

Non-chemotherapy drugs: Code 90782 is to be used for the first subcutaneous or intramuscular injection of a non-chemotherapeutic drug administered with the chemotherapy for each service date. Code 90784 is to be used for the first intravenous injection of a non-chemotherapeutic drug. If more than one non-chemo drug is administered by either or both of these methods of injection, the unlisted code (90799) must be shown with one charge per service date for all the additional drugs given. The drug name, strength or potency and dosage/quantity for each drug given must be entered in the description field of the claim (24C) or on an attachment to the claim. The NDC number(s) may also be shown, if available.

Supplies: Use CPT code 99070 one time per service date with one total charge for all covered supplies used for the chemotherapy session. Examples of payable supplies are IV solutions, needles, IV tubing, and venosets. A complete description of each supply used must be shown in the description field (24C) or on an attachment to the claim.

NOTE: If an attachment is used to identify or describe the chemo and non-chemo drugs and supplies, please separate the items by type of drug, i.e. chemo or non-chemo or supplies.